

**State of Vermont**  
**Certification of Health Care Provider - Family Member**  
**(Family and Medical Leave Act of 1993)**  
**(Vermont Parental and Family Leave)**

**This form is to be completed when the employee needs family leave to care for a FAMILY MEMBER with a "serious illness."**

Employee's Name: \_\_\_\_\_ Department: \_\_\_\_\_

Name of Family Member: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Release of Medical Information:** I authorize the release of any medical information necessary to provide the information requested on this form.

Patient's OR Patient Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SERIOUS HEALTH CONDITION:**

1. Form (PERFMLA 5) describes what is meant by a "**serious health condition**"<sup>1</sup> under the State and Federal Family and Medical Leave Acts. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.

- |           |   |
|-----------|---|
| _____ (1) | Hospital Care   |
| _____ (2) | Absence Plus Treatment                                  |
| _____ (3) | Pregnancy   |
| _____ (4) | Chronic Conditions Requiring Treatments                 |
| _____ (5) | Permanent/Long-Term Conditions Requiring Supervision    |
| _____ (6) | Multiple Treatments (Non-Chronic Conditions)            |
| _____ (7) | None of the above: Please specify why leave is required |

Date Condition Began: \_\_\_\_\_

Date Condition Expected to End: \_\_\_\_\_

2. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one or more of these categories:

**TREATMENTS:**

3. Will the patient be absent from work or other daily activities on an **intermittent** or **reduced schedule** basis because of **treatment**?

\_\_\_\_\_ Yes  
\_\_\_\_\_ No

If Yes: Number of treatments: \_\_\_\_\_

Interval between treatments: \_\_\_\_\_

Dates of treatments: \_\_\_\_\_

Period of recovery: \_\_\_\_\_

4. If any of these treatments will be provided by **another provider of health services** (e.g., physical therapist), please state the nature of the treatments:

\_\_\_\_\_  
<sup>1</sup> Here and elsewhere on this form the information sought relates only to the patient's condition for which the employee is taking FMLA

5. If a **regimen of continuing treatment** by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

**INCAPACITY:**

6. Is the patient **presently incapacitated**<sup>2</sup>?

☐ Yes

☐ No

If yes, give the probable duration: \_\_\_\_\_

7. If the condition is a **chronic condition** or **pregnancy**, are **episodes of incapacity likely**?

☐ Yes

☐ No

If yes, give the probable duration of episodes: \_\_\_\_\_

If yes, give the probable frequency of episodes: \_\_\_\_\_

**CARE PROVIDER:**

8. **Does the patient require assistance** for basic medical or personal needs or safety, or for transportation?

☐ Yes

☐ No

If yes, give the probable duration: \_\_\_\_\_

9. Would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery?

☐ Yes

☐ No

If yes, give the probable duration: \_\_\_\_\_

Signature of Physician or Health Care Provider: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Telephone Number)

Type of Practice or Specialization: \_\_\_\_\_

**To be completed by the EMPLOYEE needing family leave to care for a family member:**

State the care to be provided by the employee and an estimate of the time period necessary to provide this care. If an intermittent or reduced leave schedule is required, please include the schedule:

\_\_\_\_\_  
(Employee Signature)

\_\_\_\_\_  
(Date)

**Note:** Employee is advised to refer to the **Employee Request** form (PERFMLA 1) for information regarding intermittent or reduced leave schedules because these schedules may affect an employee's leave accrual and other benefits.

**ALL DOCUMENTATION RELATED TO FAMILY LEAVE MUST BE FORWARDED TO YOUR DEPARTMENT'S HUMAN RESOURCES SECTION FOR RECORD KEEPING. WRITTEN INFORMATION RELATED TO FAMILY LEAVE IS CONSIDERED CONFIDENTIAL AND IS KEPT IN A MEDICAL FILE IN YOUR DEPARTMENT'S PERSONNEL UNIT.**

<sup>2</sup> Incapacity, for purposes of FMLA, is defined to mean the inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.